

EARLY INTERVENTION SERVICES INTAKE FORUM REFERRAL FORM

PERSONAL DETAILS				
Child's Name		Date of Birth		
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Child's Age Years Months		
Address of child		Does your child attend Crèche <input type="checkbox"/> Pre-school <input type="checkbox"/> School <input type="checkbox"/> N/A <input type="checkbox"/> Contact number: _____		
Mother's Name Telephone: Mobile Landline Address (if different from child's)		Father's Name Telephone: Mobile Landline Address (if different from child's)		
Names of Legal Guardian(s) _____ (see page 8 for definition) Who does the child live with _____				
Siblings Name	Age	Involved in other services Yes No		Details
REFERRAL INFORMATION				
What are the main concerns regarding your child's development				
1. _____				
2. _____				
3. _____				

Has a diagnosis been made or a condition identified	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
If yes what is the diagnosis/condition	
Are there or have there been other services involved with your child	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
If yes please list	
What is the main language spoken in the home	
Do you require an interpreter	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
BIRTH HISTORY	
Length of pregnancy Weeks Days	Birth weight
Was your child admitted to the neonatal unit	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
If yes please describe	
Has your child been in hospital since he/she was born	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes for what reason	
EYESIGHT	
Do you have concerns about your child's eyesight	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Has your child's eyesight been tested	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
If yes what was the outcome	
HEARING	
Do you have concerns about your child's hearing	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Has your child's hearing been tested	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
If yes what was the outcome	

YOUR CHILD'S DEVELOPMENT

Please complete all sections

Note that some questions may not be relevant to your child

MOVEMENT

Has your child achieved the following (please tick ✓ the appropriate box)			
		If yes at what age	
Rolling from tummy to back	Yes <input type="checkbox"/> No <input type="checkbox"/>		Not Sure <input type="checkbox"/>
Sitting without support	Yes <input type="checkbox"/> No <input type="checkbox"/>		Not Sure <input type="checkbox"/>
Crawling (on all fours)	Yes <input type="checkbox"/> No <input type="checkbox"/>		Not Sure <input type="checkbox"/>
Bottom Shuffling	Yes <input type="checkbox"/> No <input type="checkbox"/>		Not Sure <input type="checkbox"/>
Pulling to stand	Yes <input type="checkbox"/> No <input type="checkbox"/>		Not Sure <input type="checkbox"/>
Walking independently	Yes <input type="checkbox"/> No <input type="checkbox"/>		Not Sure <input type="checkbox"/>
Running	Yes <input type="checkbox"/> No <input type="checkbox"/>		Not Sure <input type="checkbox"/>
Jumping	Yes <input type="checkbox"/> No <input type="checkbox"/>		Not Sure <input type="checkbox"/>

Manipulation of small objects (e.g. picking up raisins or pasta)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Playing with constructional games (e.g. Jigsaw/Lego)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Using a pencil/pen	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Cutting with scissors	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>

Do any of the following describe your child's movement

Trips a lot	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Falls a lot	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Tires easily	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Bumps into things a lot	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Always on the go	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>

Any further comments about your child's movement

DAILY LIVING SKILLS

(Note that some questions may not be relevant to your child)

Do you have concerns about your child's eating and drinking	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
If yes please describe	
Is your child a fussy eater	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
If yes please describe	
Can your child	
Use a cup independently	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Use a spoon independently	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Use a fork independently	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Undress independently	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Dress independently	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Is your child toilet trained by day	Yes <input type="checkbox"/> No <input type="checkbox"/> Age
Is your child toilet trained by night	Yes <input type="checkbox"/> No <input type="checkbox"/> Age
Do you have concerns about your child's sleep	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes please describe	
Any further comments about your child's daily living skills	

SPEECH, LANGUAGE AND COMMUNICATION

(Note that some questions may not be relevant to your child)

Do you have concerns about your child's ability to communicate	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Does your child use gestures (e.g. wave bye bye and point)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
What age did your child say his/her first words	Age

Do any of the following describe your child's speech, language and communication ability	
My child has difficulty understanding what I say	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
My child has difficulty expressing him/herself (e.g. the amount of words my child can say)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
My child has difficulty with speech (e.g. my child's speech is difficult to understand compared to other children)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
If yes to any of the above please describe	
Any further comments about your child's speech, language and communication	

BEHAVIOUR AND EMOTIONS (Note that some questions may not be relevant to your child)				
Do you have concerns about your child's behaviour	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>			
Is your child's behaviour difficult to manage	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>			
If yes please describe				
Do any of the following describe your child (please tick ✓ relevant boxes)				
Frequent Tantrums	Aggressive	Irritable	Excessive crying	Upset for minor reasons
Withdrawn /too quiet	Doesn't like change	Clingy	Frustrated	Worries a lot
Any further comments about your child's behaviour and emotions				

PLAY (Note that some questions may not be relevant to your child)	
Do any of the following describe your child's play	
Prefers to play alone	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Prefers to play next to other children but not with them	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>

Prefers to play with other children	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
Prefers to play with adults	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
My child will take turns when playing with other children	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
My child will share toys with other children	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
My child shows an interest in other children	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
What toys does your child prefer to play with	
What activities does your child like doing	
Any further comments about your child's play	

LEARNING	
(Note that some questions may not be relevant to your child)	
Do you have concerns about your child's ability to learn new skills	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
If yes please describe	
Has anyone ever expressed concern about your child's ability to learn (e.g. pre-school teacher, PHN, GP, family member etc)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
If yes please give details	
Do you have concerns about your child's ability to concentrate	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>
If yes please give details	
Any further comments about your child's learning	

Additional Family Information you feel is relevant to your child's referral

Please comment

I/we also give consent to the Intake Forum or designated Early Intervention Services to contact and obtain relevant information from:

PROFESSIONAL	NAME	CONTACT DETAILS
General Practitioner (GP)		
Public Health Nurse (PHN)		
Speech and Language therapist		
Psychologist		
Occupational therapist		
Physiotherapist		
Social worker		
Paediatrician		
Crèche/Preschool/School		
Audiologist (hearing)		
Ophthalmologist (vision)		
Assessment of need officer		
Other		

Definition of Legal Guardian of a child

- o Where the child's parents are not married, the child's mother only.
- o Where the child's parents are not married, the mother of the child & the child's father or any other named person when appointed guardian further to a successful court application for guardianship.
- o Where both parents are married, the child's mother and father are legal guardians.
- o Following a separation or divorce, both parents remain the child's legal guardian, even if the child is not living with them and they have not been awarded custody of the child.
- o Where the children's parents are not married and the mother of the child and the child's father have entered into an agreement which has the effect of making the father the guardian of the child.

REFERRER'S DETAILS

This form was completed by

Mother

Yes No

Father

Yes No

Health Professional

Yes No

HEALTH PROFESSIONAL DETAILS

Name and profession _____

Phone Work _____

Mobile No. _____

Signature _____

Date completed _____

CONSENT

It is required by law that at least one of the child's legal guardian consents to the referral and signs this form. It is advisable that the parent(s)/guardian(s) are aware of this referral

I/we give permission for my/our child to be referred to the Early Intervention Service Intake Forum


Do you agree that in the event that this referral is not appropriate for the Early Intervention Service this referral form may be shared with other relevant services to facilitate an onward referral

Yes No

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Please return all referral forms to:


Please Return To:
Early Intervention Forum – South Lee,
Room 20, Block 8,
St. Finbarr's Hospital,
Douglas Road, Cork

ADDITIONAL INFORMATION IS ALWAYS USEFUL
PLEASE ATTACH IF AVAILABLE

FOR OFFICE USE ONLY

To be completed at Early Services Referral Forum meeting

Referral presented for discussion on ___/___/___

Referral was assigned to: _____

Signed: _____
(on behalf of Early Services Referral Forum meeting)